



ARKANSAS STATE BOARD OF PUBLIC ACCOUNTANCY
101 East Capitol, Suite 450 Little Rock, AR 72201
Phone (501) 682-1520 Fax (501) 682-5538
www.arkansas.gov/asbpa

WRITTEN NOTIFICATION OF **DEMOGRAPHIC CHANGES ONLY - INDIVIDUAL**

Complete **ALL** sections and return to the Board.

The Board of Accountancy **must** be notified in writing within 30 days of name/address/employment change (Rule 9.1).

SSN: XXX - XX - _____
(Enter the last 4 digits of your SSN)

CERTIFICATE # _____

(The disclosure of your Social Security Number (SSN) is **mandatory**; it is solicited by the authority granted by 42 U.S.C. §666(a) (13) and A.C.A §17-1-104. It will be provided to the Arkansas Office of Child Support Enforcement for child support purposes. The failure to provide your SSN in this application will result in the denial of your application. Your SSN is not subject to public disclosure under the Freedom of Information Act; the disclosure of your SSN without your consent is a class B misdemeanor.)

Name: _____
Last Name First Middle

Physical Residential Information

Current: _____ Previous: _____

Phone: _____

Phone: _____

Email: _____

Email: _____

Employment Information

Current: _____ Previous: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Email: _____

Email: _____

Preferred mailing address (please check)

Residential Address _____ Business Address _____ **Other (please complete the information below) _____

** Post office box address

Signature _____ Date _____